SERFF Tracking Number:	*AEGX-126183823*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*42636*
Company Tracking Number:	*HA AR0047915F01*		
TOI:	*H04 Health - Blanket Accident/Sickness*	*Sub-TOI:*	*H04.000 Health - Blanket Accident/Sickness*
Product Name:	*Accidental Death*		
Project Name/Number:	*Accidental Death/HA AR0047915F01*		

Filing at a Glance

Company: Stonebridge Life Insurance Company

Product Name: Accidental Death	SERFF Tr Num: AEGX-126183823	State: ArkansasLH
TOI: H04 Health - Blanket Accident/Sickness	SERFF Status: Closed	State Tr Num: 42636
Sub-TOI: H04.000 Health - Blanket Accident/Sickness	Co Tr Num: HA AR0047915F01	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Author: SPI ADMSLH	Disposition Date: 06/17/2009
	Date Submitted: 06/09/2009	Disposition Status: Approved-Closed
Implementation Date Requested:		Implementation Date:

State Filing Description:

General Information

Project Name: Accidental Death	Status of Filing in Domicile:
Project Number: HA AR0047915F01	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type:
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 06/17/2009	Explanation for Other Group Market Type:
	State Status Changed: 06/17/2009
Deemer Date:	Corresponding Filing Tracking Number:

Filing Description:

RE: Stonebridge Life Insurance Company

NAIC # 0468-65021

FEIN: 03-0164230

SLAD3400BP: Blanket Accidental Death Policy

Dear Commissioner:

SERFF Tracking Number:	*AEGX-126183823*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*42636*
Company Tracking Number:	*HA AR0047915F01*		
TOI:	*H04 Health - Blanket Accident/Sickness*	*Sub-TOI:*	*H04.000 Health - Blanket Accident/Sickness*
Product Name:	*Accidental Death*		
Project Name/Number:	*Accidental Death/HA AR0047915F01*		

Attached for your review and approval is a copy the above captioned form. This form is new and does not replace any form previously approved by your Department. The form has been completed in "John Doe" fashion. Variable information is bracketed and printed in red. An Explanation of Variables is included for your reference.

SLAD3400BP is an Accidental Death Blanket Policy. It provides benefits for any insured who suffers loss of life as a result bodily injury caused by an accident. At the option of the Policyholder, the Policy may also provide benefits for Dismemberment.

This policy will be issued in the state of Texas. The Texas Department of Insurance approved this policy on June 2, 2009.

The Flesch score for this policy is 45.9. Microsoft Word was used to obtain this score.

We request approval for general use of various discretionary groups. The policy will initially be issued to Netspend Corporation. This group is not a trust.

We request approval of these forms in various dimensions, format and shading/colors. No dimension/format/shading/color change would produce unacceptable print.

This product will be mass marketed by point of sale transactions and possibly through other direct response marketing channels including direct mail, telemarketing methods, Internet.

Completed filing forms are attached. Our filing fee is being sent via EFT.

I respectfully request your favorable review and approval. We appreciate your consideration of these forms. Should you have any questions, please feel free to call us toll free at (877) 527-6444, Extension 6289 or contact me by e-mail at mfrei@aegonusa.com.

Sincerely,

STONEBRIDGE LIFE INSURANCE COMPANY

SERFF Tracking Number:	*AEGX-126183823*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*42636*
Company Tracking Number:	*HA AR0047915F01*		
TOI:	*H04 Health - Blanket Accident/Sickness*	*Sub-TOI:*	*H04.000 Health - Blanket Accident/Sickness*
Product Name:	*Accidental Death*		
Project Name/Number:	*Accidental Death/HA AR0047915F01*		

Margaret Frei, ACS, AIRC, ACP, CCP, HIA, HCSA

Company and Contact

Filing Contact Information

Margaret Frei, Filing Specialist
2700 W Plano Parkway
Plano, TX 75075

mfrei@aegonusa.com
(972) 881-6289 [Phone]
(972) 881-4097[FAX]

Filing Company Information

Stonebridge Life Insurance Company
29 South Main Street
Rutland, VT 05701-5014
(410) 685-5500 ext. [Phone]

CoCode: 65021
Group Code: 468
Group Name:
FEIN Number: 03-0164230

State of Domicile: Vermont
Company Type: Life and Health
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Stonebridge Life Insurance Company	$50.00	06/09/2009	28464670

SERFF Tracking Number:	*AEGX-126183823*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*42636*
Company Tracking Number:	*HA AR0047915F01*		
TOI:	*H04 Health - Blanket Accident/Sickness*	*Sub-TOI:*	*H04.000 Health - Blanket Accident/Sickness*
Product Name:	*Accidental Death*		
Project Name/Number:	*Accidental Death/HA AR0047915F01*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/17/2009	06/17/2009

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	06/16/2009	06/16/2009	SPI ADMSLH	06/17/2009	06/17/2009

SERFF Tracking Number:	*AEGX-126183823*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*42636*
Company Tracking Number:	*HA AR0047915F01*		
TOI:	*H04 Health - Blanket Accident/Sickness*	*Sub-TOI:*	*H04.000 Health - Blanket Accident/Sickness*
Product Name:	*Accidental Death*		
Project Name/Number:	*Accidental Death/HA AR0047915F01*		

Disposition

Disposition Date: 06/17/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AEGX-126183823*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*42636*
Company Tracking Number:	*HA AR0047915F01*		
TOI:	*H04 Health - Blanket Accident/Sickness*	*Sub-TOI:*	*H04.000 Health - Blanket Accident/Sickness*
Product Name:	*Accidental Death*		
Project Name/Number:	*Accidental Death/HA AR0047915F01*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Supporting Document	Explanation of Variables	Approved-Closed	Yes
Supporting Document	AR - NAIC TRANSMITTAL DOCUMENT	Approved-Closed	Yes
Supporting Document	AR - NAIC FORM FILING ATTACHMENT	Approved-Closed	Yes
Form	Blanket Accidental Death Policy	Approved-Closed	Yes
Form	Policy Change Endorsement	Approved-Closed	Yes

SERFF Tracking Number:	*AEGX-126183823*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*42636*
Company Tracking Number:	*HA AR0047915F01*		
TOI:	*H04 Health - Blanket Accident/Sickness*	*Sub-TOI:*	*H04.000 Health - Blanket Accident/Sickness*
Product Name:	*Accidental Death*		
Project Name/Number:	*Accidental Death/HA AR0047915F01*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	06/16/2009
Submitted Date	06/16/2009
Respond By Date	

Dear Margaret Frei,

This will acknowledge receipt of the captioned filing.

Objection 1

- Blanket Accidental Death Policy (Form)

Comment:

The face page of the policy needs to be amended to add the language listed below:

Any certificates issued in Arkansas will be governed by the State of Arkansas.

Objection 2

- Blanket Accidental Death Policy (Form)

Comment:

Under the Time of Payment of Claims, A health carrier shall pay or deny a clean claim within 30 days after receipt by the Health Carrier if the claim was submitted electronically, or within 45 days after receipt if the claim was submitted by other means. Refer to Rule & Reg. 43, Section 12.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	06/17/2009
Submitted Date	06/17/2009

Dear Rosalind Minor,

Comments:

SERFF Tracking Number:	*AEGX-126183823*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*42636*
Company Tracking Number:	*HA AR0047915F01*		
TOI:	*H04 Health - Blanket Accident/Sickness*	*Sub-TOI:*	*H04.000 Health - Blanket Accident/Sickness*
Product Name:	*Accidental Death*		
Project Name/Number:	*Accidental Death/HA AR0047915F01*		

Dear Ms. Minor:

In reply to your Objection Letter dated June 16, 2009, we would like to provide the following response.

Response 1

Comments: 1. We have amended the Policy with Policy Change Endorsement PCE SLAD3400BP to indicate that any certificates issued in Arkansas will be governed by the State of Arkansas. A copy of this Endorsement is attached for your review.

2. It is our belief that the requirements of Rule & Reg 43, Section 12 regarding the Time of Payment of Claims does not apply to this product. The requirements are specific to a Health Carrier as defined under Section 5(m) of Rule 43. The definition of Health Carrier includes a health maintenance organization, hospital Medicare service corporation or a disability insurance company, that issues Health Insurance Contracts as defined in Subsection 5(s) of Rule 43. Subsection 5(s) specifically excludes accident only coverage from the scope of this requirement. Because the submitted form provides accident only coverage, we feel that the requirements of Rule & Reg 43, Section 12 do not apply to this product. As a result, we respectfully request that you accept the Time of Payment of Claims without revision.

Related Objection 1

Applies To:

- Blanket Accidental Death Policy (Form)

Comment:

The face page of the policy needs to be amended to add the language listed below:

Any certificates issued in Arkansas will be governed by the State of Arkansas.

Related Objection 2

Applies To:

- Blanket Accidental Death Policy (Form)

Comment:

Under the Time of Payment of Claims, A health carrier shall pay or deny a clean claim within 30 days after receipt by the Health Carrier if the claim was submitted electronically, or within 45 days after receipt if the claim was submitted by other means. Refer to Rule & Reg. 43, Section 12.

Changed Items:

SERFF Tracking Number:	*AEGX-126183823*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*42636*
Company Tracking Number:	*HA AR0047915F01*		
TOI:	*H04 Health - Blanket Accident/Sickness*	*Sub-TOI:*	*H04.000 Health - Blanket Accident/Sickness*
Product Name:	*Accidental Death*		
Project Name/Number:	*Accidental Death/HA AR0047915F01*		

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Policy Change Endorsement	PCE SLAD340 0BP		Certificate Amendment, Insert Page, Endorsement or Rider	Initial		0	PCE SLAD340 0BP.PDF

No Rate/Rule Schedule items changed.

We believe the objection raised in the Objection Letter dated June 16, 2009 has been addressed with the above information. Thank you for your continued consideration of our filing. Should you have any questions, please call me toll free at (877) 527-6444, Extension 6289 or contact me by e mail at mfrei@aegonusa.com.

Sincerely,

STONEBRIDGE LIFE INSURANCE COMPANY
Margaret Frei, ACS, AIRC, ACP, CCP, HIA, HCSA

Sincerely,
SPI ADMSLH

SERFF Tracking Number:	*AEGX-126183823*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*42636*
Company Tracking Number:	*HA AR0047915F01*		
TOI:	*H04 Health - Blanket Accident/Sickness*	*Sub-TOI:*	*H04.000 Health - Blanket Accident/Sickness*
Product Name:	*Accidental Death*		
Project Name/Number:	*Accidental Death/HA AR0047915F01*		

Form Schedule

Lead Form Number: SLAD3400BP

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	SLAD3400BP	Policy/Contract/Fraternal Certificate	Blanket Accidental Death Policy	Initial		46	SLAD3400BP.PDF
Approved-Closed	PCE SLAD3400BP	Certificate Amendment, Insert Page, Endorsement or Rider	Policy Change Endorsement	Initial		0	PCE SLAD3400BP.PDF

STONEBRIDGE LIFE INSURANCE COMPANY

A STOCK COMPANY
Home Office: Rutland, Vermont
Administrative Office: [2700 West Plano Parkway
Plano, Texas 75075]

Stonebridge Life Insurance Company
(Herein called the Company)

Having issued this Policy to

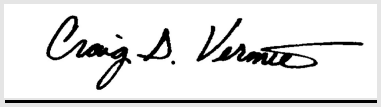
[NETSPEND CORPORATION]
(Herein called Policyholder)

Agrees to pay the benefits herein provided with respect to persons Insured hereunder, subject to all terms of this Policy.

This Policy is issued in consideration of the payment of premium and statements made in the application herein provided, and shall take effect on [MAY 1, 2009] which shall be its date of issue. Policy anniversaries shall be [YEARLY] and each subsequent [YEAR]. This is a legal contract between Stonebridge Life Insurance Company and the Policyholder.

This Policy is issued in the State of Texas, and its terms shall be construed in accordance with the laws of the State of Texas.

The provisions and conditions of this Policy shall form a part of the contract as fully as if recorded in detail above the signatures hereunder affixed.



Secretary

President

Policy No.: [25826 G035]

BLANKET ACCIDENT INSURANCE POLICY
PROVIDING ACCIDENTAL DEATH [AND DISMEMBERMENT] BENEFITS
RENEWABLE AT THE OPTION OF THE COMPANY OR THE POLICYHOLDER

DEFINITIONS

INSURED means a person who is a [Direct Deposit Customer of NetSpend Corporation], after the Policy effective date whose premium has been paid and coverage has become effective.

COVERAGE PERIOD means the [35 day] period immediately following a Covered Event.

COVERAGE PERIOD MAXIMUM BENEFIT AMOUNT means the maximum benefit amount payable as an Accidental Death [and Dismemberment] Benefit during any one Coverage Period. The Coverage Period Maximum Benefit Amount is the amount stated on the Schedule of Insurance for all Covered Events during any one Coverage Period.

COVERED EVENT means the execution of a [direct deposit] transaction [associated with a prepaid card load]. A Covered Event cannot be a transaction in violation of federal or state law.

INJURY means bodily harm caused by an accident which occurs while this Policy is in force. The Injury must be the direct cause of Loss, independent of all other causes. Injury must not be caused by or contributed to by disease or bodily infirmity.

LOSS means[:]
[1.] loss of life[;]
[2.] [with reference to hand or foot, complete severance at or above the wrist or ankle joint;
[3.] with reference to eye, the total and irrecoverable loss of the entire sight including best corrected vision of 20/200 or more.

Loss does not mean loss of use].

[PARTICIPATING GROUP means a group that requests to participate in the Insurance Trust known as the Policyholder and whose participation has been approved by the Company. The name of such group is shown in the Policy Schedule of Insurance.]

POLICYHOLDER means the group named on the front of this Policy.

ELIGIBILITY

Each natural person [AGE 18 THROUGH 75 WHO IS A DIRECT DEPOSIT CUSTOMER OF NETSPEND CORPORATION], with an account in good standing, is eligible to become an Insured if that person resides in a state in which the insurance coverage may legally be offered.

In no event will a corporation, partnership, or business entity, other than a natural person, be eligible to be covered.

WHEN COVERAGE BEGINS FOR EACH INSURED

Coverage for each [Direct Deposit Customer] will become effective under this Policy
1. on the date a [Direct Deposit Customer] becomes eligible
2. while this Policy is in force, and
3. an Insured has executed a Covered Event.

Coverage for an Insured's Covered Event will begin immediately upon execution of the Covered Event and will continue during the Coverage Period for that Covered Event.

TERMINATION OF COVERAGE

Termination by Policyholder. The Policyholder may terminate this Policy on the first renewal date or at any time after that date by delivering to the Company a written notice to end this Policy at least 31 days in advance of such termination.

Termination by the Company. The Company may terminate this Policy by giving the Policyholder at least 31 days notice of its intent to terminate. Such notice shall state the exact date this Policy will terminate. The Company may also end this Policy for non-payment of premium. The Company will mail a notice of such termination to the Policyholder's last address shown in its records.

Termination for each Insured. The insurance on each Insured will automatically terminate at 12:01 A.M. on whichever of the following dates occurs first:

1. the date that he or she no longer fulfills the requirements of an Insured as defined;
2. the date this Policy is terminated or cancelled; or
3. the end of the Coverage Period for the Covered Event.

Termination shall be without prejudice to any claim originating prior to the effective date of termination.

ACCIDENTAL DEATH [AND DISMEMBERMENT] COVERAGE

If an Insured suffers a Loss as a direct result of an Injury from an accident not otherwise excluded in this Policy, the Company will pay the Benefit Amount shown in the Policy Schedule of Insurance[, subject to the Schedule of Losses and Benefits] when the Company receives proof that:

1. the Injury caused by an accident occurred during the Coverage Period (the [35 day] period immediately following the Covered Event) and
2. Loss occurred within [90] days following the date of the accident that caused the Injury.

[SCHEDULE OF LOSSES AND BENEFITS	
LOSS	**BENEFIT**
LIFE	THE BENEFIT AMOUNT
Both Hands or Both Feet or Sight of Both Eyes	The Benefit Amount
One Hand and One Foot	The Benefit Amount
One Hand and Sight of One Eye	The Benefit Amount
One Foot and Sight of One Eye	The Benefit Amount
One Hand or One Foot or Sight of One Eye	One-Half the Benefit Amount

Benefit Amounts are as specified in the Policy Schedule of Insurance. Only one of the above benefits, the largest, will be paid for multiple Losses that result from one accident.]

In the event of a Loss covered by this Group Policy, the Company will pay the Accidental Death [and Dismemberment] Benefit shown in the Policy Schedule of Insurance for each Insured [in equal monthly installments for a period of [12] consecutive months from the date of Loss]. The benefit amount payable is subject to the Coverage Period Maximum Benefit Amount and the Maximum Benefit Amount Payable for each Insured. These amounts are shown on the Policy Schedule of Insurance.

EXCLUSIONS

No benefit shall be paid for Loss or Injury that is caused by, results from or contributed to by:

1. an intentionally self-inflicted Injury, suicide, or any attempt at suicide, while sane or insane (in Colorado and Missouri, while sane);
2. any active participation in a riot, insurrection or war, either declared or undeclared;
3. the Insured's taking or using any narcotic, barbiturate or any other drug or medication, unless taken or used as prescribed by a physician;
4. the Insured's blood alcohol level being .08 percent weight by volume or higher;
5. the Insured's operating or riding in any kind of aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight;
6. an accident which occurs outside the United States, [or] Canada [or Mexico];
7. the Insured committing or attempting to commit a felony or an assault or being engaged in an illegal activity;
8. sickness, bodily or mental infirmity or their medical or surgical treatment including diagnosis (except bacterial infections which result from an Injury) or mental disease or disorder;
9. voluntary gas inhalation or poison voluntarily taken, administered or inhaled;
10. taking alcohol in combination with any drug, medication or sedative;
11. military or combat activities while serving in the armed forces, National Guard or organized reserve corps in any state, country or international authority; or
12. riding or driving as a professional in any kind of race for prize money or profit.

PREMIUM

The single Premium for an Insured's Coverage Period will be paid by the [Participating Group/Policyholder]. Premiums for each Insured are on the Policy Schedule of Insurance.

All premiums due by the terms of this Policy shall be paid by the [Participating Group/Policyholder] to the Administrative Office of the Company on or prior to the day they are due.

The premium rates may be changed at any time the terms of the Policy are changed. The Company will provide written notice to the Policyholder at least 60 days before the date of the change.

BENEFICIARY

[All benefits are payable to the Insured, if living]. At the Insured's death[, unless otherwise specified,] any benefit due for Loss will be paid as follows:

1. to the Insured's living lawful spouse; or if there is not one,
2. in equal shares to the Insured's living lawful children; or if there are none,
3. in equal shares to the Insured's living lawful parents; or if there are none,
4. in equal shares to the Insured's living lawful brothers and sisters; or if there are none,
5. to the Insured's estate.

Spouse means only the one to whom the Insured is lawfully married on the date of the Insured's death. Except in the case of a legal adoption, lawful children, parents, brothers and sisters do not mean "step" children, parents, brothers or sisters.

GENERAL PROVISIONS

ENTIRE CONTRACT

This Policy is issued in consideration of the application and payment of the premium. The Policy and a copy of the application from the Policyholder form the entire contract of insurance.

Any change in this Policy must be in the form of an amendment or endorsement signed by one of the officers of the Company. Agreements made by the Policyholder and the Company in this manner will be binding on all persons insured.

INFORMATION TO BE FURNISHED

The Policyholder shall furnish the Company with any information required to administer this Policy. The Company shall have the right to inspect any record of the Policyholder or in possession of the Policyholder which relates to this Policy. We may do this at any time within two years after this Policy terminates.

CLERICAL ERROR

A clerical error in the records relative to this insurance shall not invalidate insurance or cause insurance to be in force or to continue in force. Upon discovery of such error, an equitable adjustment shall be made in the premium.

NOTICE OF CLAIM

Written notice of claim must be given to the Company within 30 days after a covered Loss occurs. If it is not reasonably possible to furnish notice within that time, it must be given as soon as possible. Notice should be mailed to the Company at its administrative office. The notice should contain the Insured's name and enough information to identify him.

CLAIM FORMS

When the Company receives the Notice of Claim, the Company will send the claimant forms for filing Proof of Loss. If the Company does not send the forms within 15 days, the claimant can meet the Proof of Loss requirement by providing the Company with a written statement describing what happened. The Company must receive this statement within the time given for filing Proof of Loss.

PROOF OF LOSS

Written proof of loss must be given to the Company within 90 days after the date of the Loss or as soon as possible thereafter. Proof must, however, be furnished no later than one year from the time it is otherwise required, except in the absence of legal capacity.

TIME OF PAYMENT OF CLAIMS

The Company will pay all benefits covered by this Policy within 60 days of the Company's receipt of proper written Proof of Loss sufficient to determine liability.

[PAYMENT OF CLAIMS

[All benefits are payable to the Insured, if living]. Loss of life benefits for the Insured are payable in accordance with the beneficiary designation in effect at the time of payment. Other benefits will be paid to the Insured. Any other benefits, other than for Loss of life, unpaid at the Insured's death may be paid, at the Company's option, either to the Insured's beneficiary or estate.]

AUTOPSY [AND PHYSICAL EXAM]

The Company, at its own expense, may have an autopsy done where it is not forbidden by law. [The Company shall also have the right to examine the Insured when and as often as necessary while a claim is pending].

LEGAL ACTIONS

No action can be brought to recover on this Policy for at least 60 days after written Proof of Loss has been furnished. No such action shall be brought more than 3 years after the date Proof of Loss is required.

STONEBRIDGE LIFE INSURANCE COMPANY

SCHEDULE OF INSURANCE

This Schedule of Insurance is part of the Policy. It supersedes any Schedule of Insurance bearing an earlier effective date issued under Policy No. [25826 G035] to **[NetSpend Corporation]**.

POLICY EFFECTIVE DATE: **[05/01/2009]**

SINGLE PREMIUM: **[$0.05 PER $100.00] [FOR EACH PREPAID CARD LOAD] UP TO THE COVERAGE PERIOD MAXIMUM BENEFIT AMOUNT**

PREMIUMS ARE TO BE PAID [DAILY] FOR EACH INSURED.

THE BENEFIT AMOUNT IS EQUAL TO A TRANSACTION AMOUNT ASSOCIATED WITH A COVERED EVENT FOR EACH INSURED, SUBJECT TO THE COVERAGE PERIOD MAXIMUM BENEFIT AMOUNT.

COVERAGE PERIOD MAXIMUM BENEFIT AMOUNT PAYABLE FOR EACH INSURED **[$ 8,000.00]**

MAXIMUM BENEFIT AMOUNT PAYABLE FOR EACH INSURED **[$ 96,000.00]**

[THE ACCIDENTAL DEATH [AND DISMEMBERMENT] BENEFIT FOR EACH INSURED WILL BE PAID [IN EQUAL INSTALLMENTS FOR A PERIOD OF [12] CONSECUTIVE MONTHS FROM THE DATE OF LOSS.]

COVERAGE ENDS [35 DAYS] FOLLOWING THE COVERED EVENT.

ONLY ONE ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT, THE LARGEST, WILL BE PAID FOR MULTIPLE LOSSES THAT RESULT FROM ONE ACCIDENT.

Stonebridge Life Insurance Company

A Stock Company
Home Office: Rutland, Vermont
Administrative Office: [2700 W. Plano Parkway, Plano, Texas 75075-8200]

Policy Change Endorsement

Name of Policyholder	Policy Number	Effective Date
[Netspend Corporation].	[25826 G035]	[09/18/2009]

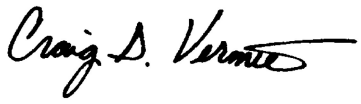
This Endorsement is effective on the date shown above and expires concurrently with the Policy to which it is attached. The Policy is amended as follows:

For residents of Arkansas:

The following disclaimer is added to the face page of the Policy:

Any certificates issued in Arkansas will be governed by the State of Arkansas.

NOTHING HEREIN CONTAINED SHALL BE HELD TO VARY, WAIVE, ALTER OR EXTEND ANY OF THE TERMS, PROVISIONS OR LIMITATIONS OF THE POLICY.



Secretary

SERFF Tracking Number:	*AEGX-126183823*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*42636*
Company Tracking Number:	*HA AR0047915F01*		
TOI:	*H04 Health - Blanket Accident/Sickness*	*Sub-TOI:*	*H04.000 Health - Blanket Accident/Sickness*
Product Name:	*Accidental Death*		
Project Name/Number:	*Accidental Death/HA AR0047915F01*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AEGX-126183823*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*42636*
Company Tracking Number:	*HA AR0047915F01*		
TOI:	*H04 Health - Blanket Accident/Sickness*	*Sub-TOI:*	*H04.000 Health - Blanket Accident/Sickness*
Product Name:	*Accidental Death*		
Project Name/Number:	*Accidental Death/HA AR0047915F01*		

Supporting Document Schedules

Review Status:

Satisfied -Name: Flesch Certification — Approved-Closed — 06/17/2009

Comments:

Attachment:

AR - READABILITY CERTIFICATION.PDF

Review Status:

Bypassed -Name: Application — Approved-Closed — 06/17/2009

Bypass Reason: N/A - This is a Blanket Policy and insureds are not required to enroll for coverage. As a result, there is not application/ enrollment form submitted with this filing.

Comments:

Review Status:

Satisfied -Name: Cover Letter — Approved-Closed — 06/17/2009

Comments:

Attachment:

Cover Letter.PDF

Review Status:

Satisfied -Name: Explanation of Variables — Approved-Closed — 06/17/2009

Comments:

Attachment:

Explanation of Variables.PDF

Review Status:

Satisfied -Name: AR - NAIC TRANSMITTAL DOCUMENT — Approved-Closed — 06/17/2009

Comments:

Attachment:

AR - NAIC TRANSMITTAL DOCUMENT.PDF

Review Status:

SERFF Tracking Number:	*AEGX-126183823*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*42636*
Company Tracking Number:	*HA AR0047915F01*		
TOI:	*H04 Health - Blanket Accident/Sickness*	*Sub-TOI:*	*H04.000 Health - Blanket Accident/Sickness*
Product Name:	*Accidental Death*		
Project Name/Number:	*Accidental Death/HA AR0047915F01*		

Satisfied -Name: AR - NAIC FORM FILING ATTACHMENT — Approved-Closed — 06/17/2009

Comments:

Attachment:

AR - NAIC FORM FILING ATTACHMENT.PDF

STATE OF ARKANSAS

READABILITY CERTIFICATION

COMPANY NAME: **Stonebridge Life Insurance Company**

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
SLAD3400BP	45.9

Signed: 

Name: Edward G. Weigand

Title: Assistant Secretary

Date: June 9, 2009

STONEBRIDGE LIFE
Insurance Company
2700 West Plano Parkway • Plano, Texas 75075-8200

June 9, 2009

The Honorable Jay Bradford
Commissioner of Insurance
Arkansas Insurance Department
Life & Health Division
1200 W 3rd St
Little Rock AR 72201-1904

Attention: Mr. Joe Musgrove

RE: Stonebridge Life Insurance Company
NAIC # 0468-65021
FEIN: 03-0164230
SLAD3400BP: Blanket Accidental Death Policy

Dear Commissioner:

Attached for your review and approval is a copy the above captioned form. This form is new and does not replace any form previously approved by your Department. The form has been completed in "John Doe" fashion. Variable information is bracketed and printed in red. An Explanation of Variables is included for your reference.

SLAD3400BP is an Accidental Death Blanket Policy. It provides benefits for any insured who suffers loss of life as a result bodily injury caused by an accident. At the option of the Policyholder, the Policy may also provide benefits for Dismemberment.

This policy will be issued in the state of Texas. The Texas Department of Insurance approved this policy on June 2, 2009.

The Flesch score for this policy is 45.9. Microsoft Word was used to obtain this score.

We request approval for general use of various discretionary groups. The policy will initially be issued to Netspend Corporation. This group is not a trust.

We request approval of these forms in various dimensions, format and shading/colors. No dimension/format/shading/color change would produce unacceptable print.

This product will be mass marketed by point of sale transactions and possibly through other direct response marketing channels including direct mail, telemarketing methods, Internet.

Completed filing forms are attached. Our filing fee is being sent via EFT.

I respectfully request your favorable review and approval. We appreciate your consideration of these forms. Should you have any questions, please feel free to call us toll free at (877) 527-6444, Extension 6289 or contact me by e-mail at mfrei@aegonusa.com.

Sincerely,

STONEBRIDGE LIFE INSURANCE COMPANY

Margaret Frei

Margaret Frei, ACS, AIRC, ACP, CCP, HIA, HCSA

Explanation of Variables for SLAD3400GP

Blanket Policy
Page 1

1. Stonebridge Life Insurance Company has several administrative office locations. This product may be solicited from one of three locations, depending on the market. The address on the forms will be one of the following:

   2700 West Plano Parkway
   Plano, Texas 75075-8200

   520 Park Avenue
   Baltimore, Maryland 21201

   Valley Forge, Pennsylvania 19493

2. Policyholder name will be the business partner name to which the coverage is issued.
3. Effective date is the date of issue of the policy and anniversaries are determined by agreement between the policyholder and the company.
4. Policy number is unique to the policyholder.
5. Dismemberment benefits will be offered if the policyholder wants to offer that benefit in addition to the accidental death benefit.

Page 2

1. The definition of insured will be determined by the policyholder and is determined by the type of customers of the policyholder.
2. The range for the number of days in the coverage period is between 30 days and 180 days and is determined by the policyholder.
3. The definition of Coverage Period Maximum Benefit Amount will include dismemberment when dismemberment benefits are offered.
4. Covered Event is defined by the type of transactions the policyholder offers.
5. The definition of Loss will change if dismemberment benefits are offered.
6. Participating group is defined when the policy is issued to a participating group.
7. Eligibility is determined by the policyholder. The Maximum age range is 18 through 80.
8. Under “When Coverage Begins for Each Insured” the customer is identified by the business the policyholder offers.

Page 3

1. The Coverage section will include Dismemberment, the Schedule of Losses and Benefits and the sentence below the schedule when that benefit is chosen by the policyholder.
2. The number of days for loss following an injury is between 30 and 180 days.
3. If the benefit is to be paid in monthly installments, the last paragraph will include the statement and the number of installments will be 6, 12, 18 and 24 months, determined by the policyholder.

Page 4

1. Exclusion #6 will include Mexico if the policyholder chooses to cover losses in Mexico.
2. The language in Beneficiary will change depending on whether dismemberment benefits are offered.

Page 5

1. The Payment of Claims provision will be used when dismemberment benefits are offered.
2. The provision Autopsy will be used with accidental death benefits. Physical exam will be added when dismemberment benefits are offered.

Page 6

1. The Schedule page information is determined by the benefits and amounts chosen by the policyholder.

2. Premiums will be paid daily, weekly or monthly as determined by agreement between the policyholder and the company. The number of premiums are also determined by the program offered by the policyholder.

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	**Prepared for the State of**	Arkansas

2.	**Department Use Only**
	State Tracking ID

3.	**Insurer Name & Address**	**Domicile**	**Insurer License Type**	**NAIC Group #**	**NAIC #**	**FEIN #**	**State #**
Stonebridge Life Insurance Company 29 South Main Street Rutland VT 05701-5014		VT	Life, Accident and Health	468	65021	03-0164230	

4.	**Contact Name & Address**	**Telephone #**	**Fax #**	**E-mail Address**
Margaret A. Frei, AIRC, ACS, ACP 2700 W Plano Parkway Plano TX 75075		877-527-6444 Ext. 6289	972-881-4097	mfrei@aegonusa.com

5.	**Requested Filing Mode**	☒ Review & Approval ☐ File & Use ☐ Informational ☐ Combination (please explain): _____ ☐ Other (please explain): _____

6.	**Company Tracking Number**	HA AR0047915F01
7.	☒ **New Submission** ☐ **Resubmission**	Previous file # _____
8.	**Market**	☐ Individual ☐ Franchise Group: ☐ Small ☐ Large ☐ Small and Large ☐ Employer ☐ Association ☒ Blanket ☐ Discretionary ☐ Trust ☐ Other: _____
9.	**Type of Insurance**	H04 Health - Blanket Accident/Sickness
10.	**Product Coding Matrix Filing Code**	H04.000 Health - Blanket Accident/Sickness
11.	**Submitted Documents**	☒ **FORMS** ☒ Policy ☐ Outline of Coverage ☐ Certificate ☐ Application/Enrollment ☐ Rider/Endorsement ☐ Advertising ☐ Schedule of Benefits ☐ Other: _____ ☐ **RATES** ☐ New Rate ☐ Revised Rate ☐ **FILING OTHER THAN FORM OR RATE:** Please explain: _____ **SUPPORTING DOCUMENTATION** ☐ Articles of Incorporation ☐ Third Party Authorization ☐ Association Bylaws ☐ Trust Agreement ☒ Statement of Variability ☐ Certifications ☐ Actuarial Memorandum ☐ Other: _____

12.	**Filing Submission Date**	June 9, 2009
13.	**Filing Fee (If required)**	Amount $50.00 Check Date N/A – via EFT Retaliatory ☐ Yes ☒ No Check Number N/A – via EFT
14.	**Date of Domiciliary Approval**	Approved in Texas, our situs state, on June 2, 2009.
15.	**Filing Description:**	

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Sincerely,

STONEBRIDGE LIFE INSURANCE COMPANY
Margaret Frei, ACS, AIRC, ACP, CCP, HIA, HCSA

16. Certification (If required)

I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of Arkansas.

Print Name Margaret A. Frei, AIRC, ACS, ACP Title Filing Specialist

Signature Margaret Frei Date June 9, 2009

17.	Form Filing Attachment
This filing transmittal is part of company tracking number	HA AR0047915F01
This filing corresponds to rate filing company tracking number	

	Document Name Description	Form Number		Replaced Form Number Previous State Filing Number
01	Blanket Accidental Death Policy	SLAD3400BP	☒ Initial ☐ Revised ☐ Other _____	
02			☐ Initial ☐ Revised ☐ Other _____	
03			☐ Initial ☐ Revised ☐ Other _____	
04			☐ Initial ☐ Revised ☐ Other _____	
05			☐ Initial ☐ Revised ☐ Other _____	
06			☐ Initial ☐ Revised ☐ Other _____	
07			☐ Initial ☐ Revised ☐ Other _____	
08			☐ Initial ☐ Revised ☐ Other _____	
09			☐ Initial ☐ Revised ☐ Other _____	
10			☐ Initial ☐ Revised ☐ Other _____	
11			☐ Initial ☐ Revised ☐ Other _____	